Family Psychoeducation

Implementation Resource Kit

DRAFT VERSION
2003

Family Psychoeducation Fidelity Scale

This document is intended to help guide you in administering the Family Psychoeducation (FPE) Fidelity Scale. In this document you will find the following:

- **Introduction:** This gives an overview of FPE and a who/what/how of the scale, plus a checklist of suggestions for before, during, and after the fidelity assessment that should lead to the collection of higher quality data, more positive interactions with respondents, and a more efficient data collection process.

- **Protocol:** The protocol explains how to rate each item. In particular, it provides:
  - A definition and rationale for each fidelity item. These items have been derived from comprehensive evidence-based literature.
  - A list of data sources most appropriate for each fidelity item (e.g. clinician report, chart review).
  - Decision rules that will help you correctly score each item. As you collect information from various sources, these rules will help you determine the specific rating you give for each item.
  - Where appropriate, a set of probe questions to help you elicit the critical information for scoring the fidelity item. These probe questions were specifically generated to help you collect information from respondents that is free from bias such as social desirability.

- **Cover Sheet:** This form obtains background information on the study site. These data are not used in determining fidelity, but provide important information for classifying programs, such as size and duration of program, type of parent organization, and community characteristics.
- **Checklist for Observed Sessions:** The checklist is to be used for rating Items 11 &12.
- **Score Sheet:** The scoring sheet provides instructions for scoring, including how to handle missing data. It also includes cut-off scores for full, moderate, and inadequate implementation.

Family Psychoeducation Fidelity Scale: Introduction

Overview of FPE

FPE is an evidence-based psychiatric rehabilitation practice that aims to achieve the best possible outcome for consumers with severe mental illness (SMI) through collaborative treatment between clinicians and family members of the individual with SMI. Additionally, FPE attempts to alleviate the stress experienced by family members by supporting them in their efforts to aid the recovery of their loved one. Research has demonstrated that FPE results in a 20% - 50% reduction in relapse and rehospitalization rates among consumers whose families received psychoeducation than among those receiving standard individual services (Lam, Knipers & Leff, 1993; Penn & Kim, 1996; Falloon, Held et al., 1999). Moreover, families that receive education and support feel less burden and are more effective at helping their loved ones with SMI to manage their illnesses (Dixon & Lehman, 1995).

Although the existing models of family interventions vary, leaders in the field have reached a consensus on the critical ingredients of effective FPE. They include a collaborative relationship between the treatment team and family, basic psychoeducation about psychiatric illness and its management, social support and empathy, interventions targeted to reducing tension and stress in the family as well as improving functioning in all family members (and not just the consumer), and a program length of six months or more (Dixon, McFarlane et al., 2001).

What is meant by "family"?

The term "family" is used throughout this document. It should be interpreted broadly to including anyone in the client's natural support system who is functioning as "family," regardless of any legal or biological relationship to the client. A family member could include not only parents, siblings, spouses, children, and other relatives, but also friends.

Overview of the scale

The 12-item FPE Fidelity Scale has been developed to measure the adequacy of implementation of FPE programs. Each item on the scale is rated on a 5-point rating scale ranging from 1 ("Not implemented") to 5 ("Fully implemented"). The standards used for establishing the anchors for the "fully-implemented" ratings were determined through a variety of expert sources as well as empirical research.

What is rated

The scale is rated on current behavior and activities, not planned or intended behavior. For example, in order to get the full credit for Item 1 ("Family Intervention Coordinator"), it is not enough that the program is currently planning to hire personnel to fill the position.

Unit of analysis

The scale is appropriate for organizations that are serving clients with SMI and their families. The purpose of the scale is to assess fidelity to evidence-based practices *at the program level*, rather than at the level of a specific clinician.

How the rating is done

To be valid, we believe that a fidelity assessment must be done in person, i.e., through a site visit. The fidelity assessment requires a minimum of 5 hours to complete, although a longer period of assessment will offer more opportunity to collect information and hence should result in a more valid assessment. The data collection procedures include chart review, session observation, and semi-structured interviews with the program coordinator, clinicians and supervisors, and family members.

If the FPE program has 3 or fewer clinicians, attempts should be made to interview all. If the program has more than 3 clinicians, a minimum of 3 should be sampled for an interview. It is recommended that interviews with clinicians be done in a group format.

For the items that require interviews with family members, we suggest that at least 3 family members (from unique families) be interviewed. The program coordinator should be contacted to help you identify and set up these interviews.

For some items that require chart review for rating, 10 charts shall be randomly selected. We suggest that you ask the program coordinator to select 20 charts beforehand and then randomly select and review 10 of those charts during your site visit. The charts should include one client whose family is seen for each FPE clinician to be interviewed.

Some items are to be rated by observing a session. The rating may be done either by observing a live session or by viewing a previously videotaped session, which should be determined by negotiating with each program.

Who does the ratings

The scale can be administered internally by a program or by an external review group. If it is administered internally, it is obviously important for the ratings be made objectively, based on hard evidence, rather than making ratings to "look good." Circumstances will dictate decisions in this area, but we encourage agencies to choose a review process that fosters objectivity in ratings, e.g., by involving a staff person who is not centrally involved in providing the service. With regard to external reviews, there is a distinct advantage in using assessors who are familiar with the program, but at the same time are independent. The goal in this process is the selection of objective and competent assessors.

Fidelity assessments should be administered by individuals who have experience and training in interviewing and data collection procedures (including chart reviews). In addition, interviewers need to have an understanding of the nature and critical ingredients of FPE. We recommend that all fidelity assessments be conducted by at least two assessors.

Missing data

The scale is designed to be completely filled out, with no missing data on any items. Therefore, it is essential that assessors obtain the required information for every item. If information cannot be obtained at time of the site visit, it will be important for you to be able to collect at a later date.

References

Dixon, L. & Lehman, A.F. (1995). Family interventions for schizophrenia. Schizophrenia Bulletin, 21, 631-643.

Dixon, L., McFarlane, W.R. et al. (2001). Evidence-based practices for services to families of people with psychiatric disabilities. Psychiatric Services, 52, 903-910.

Lam, D.H., Knipers, L., Leff, J.P. (1993). Family work with patients suffering from schizophrenia: The impact of training on psychiatric nurses' attitude and knowledge. Journal of Advanced Nursing, 1S, 233-237.

Penn, L.D. & Mueser, K.T. (1996). Research update on the psychosocial treatment of schizophrenia. American Journal of Psychiatry, 153, 607-617.

Falloon, I.R.H., Held, T. et al. (1999). Psychosocial interventions for schizophrenia: A review of long-term benefits of international studies. Psychiatric Rehabilitation Skills, 3, 268-290.

Fidelity Assessor Checklist

Before the Fidelity Site Visit

- *Establish a contact person at the program*. You should have one key person who arranges your visits and communicates beforehand the purpose and scope of your assessment. Typically this will be the FPE program coordinator. Exercise common courtesy in scheduling well in advance, respecting the competing time demands on clinicians, etc.

- *Review the sample cover sheet*. This sheet is useful for organizing your fidelity assessment, identifying where the specific assessment was completed, along with general descriptive information about the site. You may need to tailor this sheet for your specific needs (e.g., unique data sources, purposes for the fidelity assessment).

- *Create a timeline for the fidelity assessment*. Fidelity assessments require careful coordination of efforts and good communication, particularly if there are multiple assessors. For instance, the timeline might include a note to make reminder calls to the program site to confirm interview dates and times.

- *Establish a shared understanding with the site being assessed*. Explain the goals of the fidelity assessment, who will see the report, whether the program site will receive this information, and exactly what information will be provided. The most successful fidelity assessments are those in which there is a shared goal among the assessors and the program site to understand how the program is progressing according to evidence-based principles. If administrators or line staff at the study site fear that they will lose funding or look bad if they don't score well, then the accuracy of the data may be compromised. The best agreement is one in which all parties are interested in getting at the truth.

- *Indicate what you will need from respondents during your fidelity visit.* In addition to the purpose of the assessment, you will need to briefly describe what information you will need (e.g., schedules and curricula for sessions), who you will need to speak with, and how long each interview or visit will take to complete.

- *Alert your contact person that you will need to sample 20 charts.* It is preferable from a time efficiency standpoint that these charts and sessions be selected beforehand, using a random selection procedure. The charts should be sampled from a pool of families that have received at least 5 FPE sessions. ***The charts should include one***

client whose family is seen for each FPE clinician to be interviewed. Obviously, a program can influence the outcome of the assessment by hand picking charts and/or updating them right before the visit. If there is a shared understanding that the goal is to better understand how a program is implementing services, this is less likely to occur.

- *Alert your contact person that you will need to observe an FPE session.* Determine if a session can be observed live or via videotape during your visit; if part of or all of the session needs to be videotaped for rating, arrange so that it will have been recorded before your site visit. We recommend that the session be observed that is not one of the 3 initial sessions.

- *Alert your contact person that the fidelity assessment includes interviews with family members*. Ideally, the fidelity assessment should include interviews with a family member from 3 different families, preferably who are at different stages of the educational process.

- *Alert your contact person that you will need to interview FPE clinicians*. The intent is to interview 3 clinicians. If the program has fewer than 3 clinicians providing services, interview all clinicians. If the program has more than 3, interview at least 3.

During Your Fidelity Site Visit

Overview: The general strategy in conducting program fidelity assessments is to obtain data from as many sources as possible. When all these data sources converge, then one can be more confident in the validity of the ratings. However, experience suggests that the sources often disagree. A review of the charts should precede clinician and family interviews. If the information from different sources is not in agreement (for example, if the program coordinator indicates a higher rate of use of a particular technique than is documented in the records, or observed in the session), then ask the program coordinator to help you understand the discrepancy. The results from a chart review can be overruled if other data (e.g., team leader interview, internal statistics) refute it.

1) The first step is to review charts and/or other written sources, such as progress notes, documenting FPE sessions. Ideally, the program site uses a standardized form indicating the content of the program sessions.

2) The second step in the fidelity assessment is an interview with the FPE coordinator. The fidelity assessors should begin by reviewing the purpose for the visit and the schedule for the day. Explain that after the interview with the coordinator, you will begin by reviewing charts and that the goal is to examine the charts for each of 10 FPE consumers (preferably ones who have received FPE for at least 5 sessions). The schedule will then include observation of 1 FPE session, interviews with 3 FPE family members, and interviews with 3 clinicians.

3) The recommended schedule is as follows:

1. Review of charts
2. Interview with program coordinator, including review of program documentation (attendance rosters, curriculum materials, training schedules)
3. Observation of an FPE session
4. Interviews with 3 FPE family members
5. Interviews with 3 FPE clinicians
6. Final interview with program leader (to clarify information from the day; fill in gaps, etc.)

Tips

- *Tailor terminology used in the interview to the site.* For example, if the site uses the term "member" for consumer, use that term. If "practitioners" are referred to as clinicians, use that terminology. Every agency has specific job titles for particular staff roles. By adopting the local terminology, the assessor will improve communication.
- During the interview, *record the names of all relevant programs and staff,* the total number of families seen in FPE, and the total number of clinicians providing FPE.
- *If discrepancies between sources occur, query the program coordinator or clinicians to get a better sense of the program's performance in a particular area.* The most common discrepancy is likely to occur when the interview with the program staff gives a more idealistic picture of the program's functioning than do chart reviews or consumer interviews. To understand and resolve this discrepancy, the assessor may need to go back to the clinicians and ask questions that highlight and attempt to clarify the discrepancy.
- *Before you leave, check for missing data.* The scale is designed to be filled out completely. If information cannot be obtained at the time of the site visit, it will be important for you to be able to collect at a later date.

After Your Fidelity Site Visit

- If necessary, *follow up on any missing data* (e.g., by phone calls to the program site).
- Assuming there are two assessors, *both should independently rate the fidelity scale*. The assessors should then compare their ratings and resolve any disagreements. Determine a consensus rating.
- *Tally the item scores and determine which level of implementation was achieved* (See Score Sheet).
- *Send follow-up letter to site*. In most cases, this letter will include a *fidelity report,* explaining to the program their scores on the fidelity scale and providing some interpretation of the assessment, highlighting both strengths and weaknesses. The report should be informative, factual, and constructive. If the fidelity assessment is given repeatedly, it is often useful to provide a graph of a program's progress on the total fidelity score over time. The recipients of this report will vary according to the purposes, but typically would include the key administrators involved in the assessment.

Definitions and Scoring

Overview

Many of the items on this scale call for a calculation of *% of families for which a particular element of FPE is documented on standardized charts.* This methodology implies that documentation is critical to evidence-based practice. While documentation is an important ingredient, poor documentation for an item does not mean that there is a complete lack of fidelity, nor does excellent documentation guarantee high fidelity of implementation. Fidelity assessors should integrate their observations from multiple sources to reach a reasoned judgment about the ratings for each item. To achieve a "5" (full implementation), all data sources (program coordinator, clinicians, family members, and charts) should agree that the item is fully implemented. If most, but not all, of the clinicians understand and follow the principle or intervention measured by an item, then ordinarily that item would be rated "4." If the organization cannot produce any written documentation whatsoever for implementation of an item, the item ordinarily should not be scored higher than "3." Rate "3" if the documentation is missing, but some clinicians can explain the principle and can give specific examples during the interview. Rate "1" if the documentation is missing and clinicians cannot articulate the underlying principles.

1. Family Intervention Coordinator

Definition: One clinical administrator is designated as overseer of the family psychoeducation program for a substantial portion of his/her job (time depends on size of program). This person's role includes activities such as:

- Establishing, monitoring, and automating family intake and engagement procedures
- Advocating cases to staff
- Monitoring caseloads
- Arranging for staff training
- Training and preparing new staff
- Arranging supervision for staff

Rationale: Delivery of services to families must be subject to accountability and tracking. One effective way for mental health centers to monitor the delivery of family services is to create a position of Family Intervention Coordinator, who would also serve as the contact person for interventions, facilitate communication between staff and families, and supervise clinicians.

Sources of Information: The first obvious question is whether the organization has someone who has a title or family coordinator or equivalent. This should be determined prior to the site visit. During the fidelity visit, interview program coordinator, clinicians, and family members.

Item Response Coding: Program coordinator is the primary source of information for this item. If other sources do not report these responsibilities performed the coordinator, then fidelity assessors should follow up with program coordinator with clarifying questions and documentation (at end of the fidelity visit day or in follow-up call). If the program does not have a designated position of coordinator (or equivalent), the item would be coded as "1." If the program has a designated position of coordinator who performs all 6 tasks, the item would be coded as a "5."

Probe Questions:

For program coordinator

- What is your role in the FPE program? How much time do you devote to this? What kinds of responsibilities do you have? (Check which of the 6 tasks are performed by coordinator. Probe who performs tasks that were not mentioned, e.g., "What are your program's family intake and engagement procedures?" "Who monitors caseload?" "Who trains your staff? How is the training done?")
- Ask program coordinator to explain intake procedures, monitoring, training schedule, and supervision schedule.

For clinicians

- What functions does the program coordinator perform? Does anyone have responsibility for each of the following (Read list of 6 tasks listed above).

For family members

- What functions does the program coordinator perform?

2. *Session Frequency for Family Psychoeducation*

Definition: Families participate in at least biweekly FPE sessions.

Rationale: It is presumed that families are more successful in benefiting if sessions are offered on a regular, predictable basis.

Sources of Information: Chart review, roster of sessions, and interviews with program coordinator, clinicians, and family members.

Item Response Coding: The primary evidence for coding this item would be attendance rosters or a calendar of scheduled events, if such documents exist. The program should have some way of documenting frequency of FPE sessions. If the documentation suggests that the organization provides at least biweekly FPE sessions, the item would be coded as a "5."

Probe Questions:

For program coordinator

- How often are FPE sessions held for family members? Do you have attendance rosters, calendar of events, or other documentation to verify this?

For clinicians

- How often are FPE sessions held for family members? Do you have attendance rosters, calendar of events, or other documentation to verify this?

For family members

- How often are FPE sessions held for family members?

3. Long-Term FPE

Definition: Families are provided with long-term FPE; specifically, at least one family member participates in FPE sessions for at least 9-months.

Rationale: In general, 6-9 months of biweekly equivalent FPE sessions are required for the families to learn necessary information and problem-solving skills. Following completion of the program, the families may also benefit from booster sessions or support groups.

Sources of Information: Chart review, roster of sessions, and interviews with program coordinator, clinicians, and family members.

Item Response Coding: The primary evidence for coding this item would be a report containing the number of families completing FPE and how long they attended, records of duration of FPE groups, or attendance sheets. In the absence of written records, the assessment will depend on interviews. Excluding dropouts, if there is evidence that ≥ 90% of families receive at least 9 months of FPE sessions, the item would be coded as a "5."

Probe Questions:

For program coordinator and clinicians

- How long do family members attend FPE before they graduate? Do you have a list of the Do you have attendance rosters, calendar of events, or other documentation to verify this?

For family members

- How long attended FPE? How long do you intend to attend?

4. Quality of Clinician-Family Alliance

Definition: In individual or group sessions (approximately three sessions), the clinician engages family members and consumer with warmth, empathy, acceptance, and attention to each individual's needs and desires.

Rationale: When the alliance between clinician and family members is poor, family members are less likely participate fully or at all in FPE programs and, as a result, are less likely to benefit from FPE interventions.

Sources of Information: Interviews with clinician and family members, session observation.

Item Response Coding: The primary source for rating this item is direct observation. This item requires clinical judgment and is based on the fidelity assessor's experience. Negative indicators would include comments in interviews, FPE sessions, or charts expressing judgmental or blaming attitudes. If sources consistently indicate a strong clinician-family alliance for all FPE clinicians, the item would be coded as a "5."

Probe Questions:

For clinicians

- How do you establish rapport or develop an alliance with family members?
- How would you rate or describe your alliance with Family X (select one family with whom the clinician works) in general?
- Are there any family members with whom you feel your relationship is counterproductive or poor?

For family members

- How would you describe your relationship with Clinician X?
- Do you feel that he/she has worked to establish a good relationship with you? What has he/she done to connect with you? What has he/she done that makes it more difficult for you to work with him/her?
- What would you change about your working relationship with Clinician X to make it better?

5. *Detailed Family Reactions*

Definition: In individual or group sessions, the clinician(s) identify and specify the family's reaction to their relative's mental illness.

Rationale: A core principle of FPE is to help family members achieve a basic understanding of SMI as well as to resolve family conflict by listening and responding sensitively to each member's emotional distress related to having a family member with an SMI.

Sources of Information: Chart review of treatment plan and interviews with coordinator, clinicians, and families.

Item Response Coding: The primary data source for this item is the treatment plans in the chart review. If documented for 80% or more of involved families, and these findings are corroborated by coordinator, supervisor, clinicians, and families, the item would be coded as a "5."

Probe Questions:

For program coordinator and clinicians

- In the FPE sessions, do you address how families react emotionally or behaviorally to their family member's illness?
- What sorts of issues do you discuss?
- What sorts of activities do you engage in to help them deal with their reactions?
- Use a client chart for a family member seen by each clinician and ask the clinician to explain the specifics, including where in the chart this is documented.

For family members

- Do you spend time in the sessions discussing how you feel and react in regards to the illness?
- Does the clinician lead you in activities to help you deal with your feelings/reactions?

6. *Precipitating Factors*

Definition: In individual or group sessions, the clinician(s) identify and specify precipitating factors to their relative's mental illness.

Rationale: Exploration of factors that have precipitated relapse in the past is a crucial step to developing individualized relapse prevention and illness management strategies. Involving the consumer and the family as equal partners in the planning and delivery of treatment is a core principle of FPE.

Sources of Information: Chart review and interviews with coordinator, clinicians, and families.

Item Response Coding: The primary data source for this item is a standardized checklist or progress note in the client's chart. If documented on standardized checklist for 80% or more of involved families, corroborated by coordinator, supervisor, clinicians, and families, the item would be coded as a "5."

Probe Questions:

For program coordinator and clinicians

- Do you discuss the precipitating factors of the illness with families? *If yes*. Can you describe the process you use to discuss them? Can you show me examples?
- Use a client chart for a family member seen by each clinician and ask the clinician to explain the specifics, including where in the chart this is documented.

For family members

- Do you discuss how to identify precipitating factors for the illness in the sessions? What sorts of things do you talk about? Please give examples.
- Do you discuss ways in which you can respond once you notice these factors occurring? Are these strategies reviewed in later sessions?

7. Prodromal Signs

Definition: In individual or group sessions, the clinician(s) help families to identify and specify prodromal signs and symptoms of their relative's mental illness.

Rationale: Exploration of the consumer's prodromal signs is another crucial step to developing individualized relapse prevention and illness management strategies. Again, involvement of the consumer and the family as equal partners in the planning and delivery of treatment is a core principle of FPE.

Sources of Information: Chart review and interviews with coordinator, clinicians, and families.

Item Response Coding: The primary data source for this item is a standardized checklist or progress note in the client's chart. If documented on standardized checklist for 80% or more of involved families, corroborated by coordinator, supervisor, clinicians, and families, the item would be coded as a "5."

Probe Questions:

For program coordinator and clinicians

- Do you help identify prodromal symptoms for families? *If yes*. Can you describe the process you use to help identify them? What would be specific examples?
- Use a client chart for a family member seen by each clinician and ask the clinician to explain the specifics, including where in the chart this is documented.

For family members

- Do you discuss the signs that your family member may be becoming symptomatic?
- What sorts of things are suggested in your sessions for how to recognize the early symptoms of the mental illness? What would be specific examples? Are these suggestions reviewed in later sessions?

8. Coping Strategies

Definition: In single-family joining sessions, the clinician(s) help to identify, describe, clarify and teach coping strategies that are used by families.

Rationale: Exploration of coping strategies that have and have not worked is another crucial step to developing individualized relapse prevention and illness management strategies. Insight into patterns of ineffective interactions and behaviors is likely to motivate the family towards desired change.

Sources of Information: Chart review and interviews with coordinator, clinicians, and families.

Item Response Coding: The primary data source for this item is a standardized checklist or progress note in the client's chart. If documented on standardized checklist for 80% or more of involved families, corroborated by coordinator, supervisor, clinicians, and families, the item would be coded as a "5."

Probe Questions:

For program coordinator and clinicians

- Do you help identify coping strategies for families? *If yes*. Can you describe the process you use to help identify and implement them?
- Use a client chart for a family member seen by each clinician and ask the clinician to explain the specifics, including where in the chart this is documented.

For family members

- Do you discuss how to cope with your family members illness in the sessions? What sorts of things do you talk about?
- Do you discuss other possible ways of coping or responding? Are these strategies reviewed in later sessions?

9. Educational Curriculum

Definition: In individual or group sessions, the clinician(s) use a standardized curriculum to teach families about mental illness. The curriculum covers six topics:

- Psychobiology of mental illness
- Diagnosis and treatment
- Family reaction and its stages
- Psychosis as a family trauma
- Relapse prevention
- Family guidelines

Rationale: An educational curriculum specifies what is taught and how it is taught. To effectively teach the families new information and skills requires structure and systematic use of specific evidence-based techniques and strategies. It is therefore critical that an FPE program has a written curriculum for its clinicians to follow.

Sources of Information: Coordinator and clinician interviews and curriculum review.

Item Response Coding: The primary data sources for this rating are a written curriculum accompanied by a schedule of completed sessions, corroborated with interviews. If ≥ 90% of educational workshops (or single family sessions) cover all 6 areas, the item would be coded as a "5."

Probe Questions:

For program coordinator

- Does your program have a written curriculum for educational workshops? (***If yes, request a copy for review.***) How was it developed? How do you train your clinicians to use it? How do you ensure that your clinicians follow the curriculum? Do you periodically evaluate and update the curriculum? Do you have a schedule of completed sessions and their content?
- Ask about each of the listed areas above and whether they are included.

For clinicians

- Do you use a written curriculum or clinician's manual for your educational workshops? (***If yes***) Are there any areas you teach differently from the curriculum/ guide?
- Do you have a schedule of completed sessions and their content?
- Ask about each of the listed areas above and whether they are included.

For family members

- What has been the content of the FPE sessions? Ask about each of the listed areas above.

10. Multimedia Education

Definition: Educational materials on illness, treatment, and guidelines can be provided in several formats (e.g., written, video, web sites).

Rationale: Depending upon the family, family members may benefit from receiving educational materials in a variety of formats. Some individuals may be more likely to watch a video or search a website than read the same information in a written format.

Sources of information: Interviews with coordinator, clinicians, and families.

Item Response Coding: The primary data source for this is the presentation of the actual materials and evidence that is made available to families. If documented on standardized checklist for 80% or more of involved families, corroborated by coordinator, supervisor, clinicians, and families, the item would be coded as a "5."

Probe Questions:

For program coordinator and clinicians

- In what form(s) do you provide educational materials to families? Do you always provide the information in the same format to each family? If not, how do you approach family members about what they need? How do you ensure that every family gets access to these materials?
- Ask to see the materials.

For family members

- What types of educational materials have you been provided with? *If they suggest a variety of materials, ask* : Did you have to ask for materials in that format, or was it offered by the clinicians or program coordinator? *If they suggest only written materials have been provided, ask*: Have you ever been offered or provided with videos, website addresses or material in other formats?

11. Structured Group Sessions

Definition: FPE sessions follow a structured format consisting of:

1. Socialization
2. "Go-round" (i.e., turn-taking)
3. Response to each family member
4. Problem-solving component
5. Socialization

Rationale: Families benefit most from structured sessions that follow a predictable pattern. Clinicians must also establish a clear agenda, goals and expectations for each session.

Sources of information: Observation of sessions and interviews with coordinator, clinicians, and families.

Item Response Coding: Primary data for this item is observation of a FPE session. If documented on standardized checklist for 80% or more of involved families, corroborated by coordinator, supervisor, clinicians, and families, the item would be coded as a "5."

Probe Questions:

For program coordinator and clinicians

- Can you describe the typical FPE multi-family group session? What activities do you engage in?
- Do you have specific goals for each of the FPE sessions?

For family members

- Can you describe what you do at the beginning of each session? In the middle? At the end?
- Does session leader seem to have a structured approach to each session?
- Is it clear to you what will be accomplished in each session?

12. Structured Problem-Solving Techniques

Definition: In individual or group sessions, the clinician(s) use a standardized approach to help families with problem solving. The approach includes:

1. Select a problem for one consumer/family
2. Define the problem in behavioral terms
3. Generate at least 8 suggestions for solution to the problem
4. Explore with the consumer and family pros and cons for each suggestion
5. Have consumer and family select the best suggestion
6. With consumer and family, develop a step-by-step plan

Rationale: Studies show collaborative and structured problem-solving techniques involving setting realistic goals and priorities and breaking goals into small behavioral steps are effective in improving consumers' functioning and families' coping.

Sources of Information: Observation of a random sampling of sessions and interviews with coordinator, clinicians, and families.

Item Response Coding: The primary data source for this item is interviews with clinicians. If documented on standardized checklist for 80% or more of involved families, corroborated by coordinator, supervisor, clinicians, and families, the item would be coded as a "5."

Probe Questions:

For program coordinator and clinicians

- Do you focus on problem solving? If yes, what is/are your strategy(ies) for addressing this issue? Do you use the same set of strategies for each family?
- Listen for the list of 6 components given above. If a component is omitted, probe for whether it is included.

For the family members

- During FPE, do you discuss how to address problems that may arise? If yes, what sorts of activities do you do in the sessions to work on problems you may be having? Do you ever generate plans of action? Is it a step-by-step procedure? Can you describe the steps?

FPE Fidelity Scale Cover Sheet

Date: _____ **Assessor(s):** _____

Program Name: _____

Agency Name: _____

Contact Person:_____

☎: _____

E-mail: _____

Sources Used:

_____Chart review

_____Interview with program coordinator

_____Review of program documentation

_____Observation of a session

_____Interview with family member(s)

_____Interview with clinician(s)

_____Interview with_____
_____Interview with_____

Number of clinicians: _____

Number of families served in preceding year: _____

Date program was started: _____

FPE Fidelity Scale: Checklist for Observed Sessions for Items 11 & 12

Program Name: _____ **Session ID:** _____
Rater: _____

Item 11. Structured Group Sessions

1) Socialization	*Yes*	*No*	
2) Turn-taking	*Yes*	*No*	
3) Response to each family member	*Yes*	*No*	
4) Problem-solving component	*Yes*	*No*	
5) Socialization	*Yes*	*No*	**Rating:** _____

Item 12. Structured Problem-Solving Technique

1) Select problem for one consumer	*Yes*	*No*	
2) Define the problem in behavioral terms	*Yes*	*No*	
3) Generate at least 8 suggestions for solution	*Yes*	*No*	
4) Explore pros and cons for each solution	*Yes*	*No*	
5) Consumer and family select specific solution(s)	*Yes*	*No*	
6) Clinician and family collaboratively develop step-by-step plans for trying out the solution(s)	*Yes*	*No*	**Rating:** _____

FPE Fidelity Scale Score Sheet

Program: _____

Date of Visit: _____

Informants – Name(s) and Positions: _____, _____

Number of Records Reviewed: _____ Rater: _____

Ratings

1.	**Family Intervention Coordinator**	1	2	3	4	5
2.	**Session Frequency**	1	2	3	4	5
3.	**Long-Term FPE**	1	2	3	4	5
4.	**Quality of Clinician-Family Alliance**	1	2	3	4	5
5.	**Detailed Family Reaction**	1	2	3	4	5
6.	**Precipitation Factors**	1	2	3	4	5
7.	**Prodromal Signs**	1	2	3	4	5
8.	**Coping Strategies**	1	2	3	4	5
9.	**Educational Curriculum**	1	2	3	4	5
10.	**Multimedia Education**	1	2	3	4	5
11.	**Structured Group Sessions**	1	2	3	4	5
12.	**Structured Problem Solving**	1	2	3	4	5

TOTAL SCORE

FAMILY PSYCHOEDUCATION FIDELITY SCALE

	1	2	3	4	5
1. Family Intervention Coordinator. One clinical administrator is designated as overseer of the family psychoeducation program for a substantial portion of his/her job (time depends on size of program). This person's role should include activities such as setting up FPE services, removing barriers to implementation, overseeing training and supervision, including family members in planning and oversight activities, linking with NAMI.	Agency does not have a designated position	Agency has a designated position who performs 1 of the tasks	Agency has a designated position who performs 2 or 3 of the tasks	Agency has a designated position who performs 4 or 5 of the tasks	Agency has a designated position who performs all tasks
2. Session Frequency for Family Psychoeducation	< 3 months	Every 3 months	Every 2 months	Monthly	At least twice a month
3. Long-Term FPE	Most families receive at less than 6 months of FPE sessions	Most families receive between 6-7 months of FPE sessions	Most families receive between 7-8 months	Most families receive between 8-9 months of FPE sessions	Excluding dropouts, >90% families receive at least 9 months of FPE sessions
4. Quality of Practitioner-Family Alliance. In individual or group sessions (approximately three sessions), the practitioner engages family members and consumer with warmth, empathy, acceptance and attention to each individual's needs and desires.	Sources consistently indicate poor practitioner-family alliance (e.g., all members of family and consumer decline services or drop-out)	Sources indicate that practitioner-family-consumer alliance often poor.	Sources indicate alliance is inconsistent or barely adequate, or information is inconsistent	Sources indicate a fairly strong practitioner-family-consumer alliance.	Sources consistently indicate a strong practitioner-family-consumer alliance
5. Detailed Family Reaction. In single-family Joining sessions, the clinician(s) identify and specify the family's reaction to their relative's mental illness.	<33% of involved families	33% - 49% of involved families	50% - 64% of involved families	65%-79% of involved families	Documented on standardized checklist for 80% or more of involved families, corroborated by coordinator, supervisor, clinicians, and families.
6. Precipitating Factors. In single-family Joining sessions, the clinician(s) identify and specify precipitating factors to their relative's mental illness.	<33% of involved families	33% - 49% of involved families	50% - 64% of involved families	65%-79% of involved families	Documented on standardized checklist for 80% or more of involved families, corroborated by coordinator, supervisor, clinicians, and families.
7. Prodromal Signs. In single-family Joining sessions, the clinician(s) help families to identify and specify prodromal signs and symptoms of their relative's mental illness.	<33% of involved families	33% - 49% of involved families	50% - 64% of involved families	65%-79% of involved families	Documented on standardized checklist for 80% or more of involved families, corroborated by coordinator, supervisor, clinicians, and families.

8. Coping Strategies. In single-family Joining sessions, the clinician(s) help to identify, describe, clarify, and teach coping strategies that are used by families.	<33% of involved families	33% - 49% of involved families	50% - 64% of involved families	65%-79% of involved families	Documented on standardized checklist for 80% or more of involved families, corroborated by coordinator, supervisor, clinicians, and families.
9. Educational Curriculum. In individual or group sessions, the clinician(s) use a standardized curriculum to teach families about mental illness. The curriculum covers at least six topics: psychobiology, diagnosis, treatment and rehabilitation, reactions to experiencing psychosis as a family, relapse prevention, and family guidelines.	<33% of involved families	33% - 49% of involved families	50% - 64% of involved families	65%-79% of involved families	Documented on standardized checklist for 80% or more of involved families, corroborated by coordinator, supervisor, clinicians, and families.
10. Multimedia Education. Educational materials on illness, treatment, and guidelines are provided with choices in several formats (e.g., written, video, web sites).	<33% of involved families	33% - 49% of involved families	50% - 64% of involved families	65%-79% of involved families	Documented on standardized checklist for 80% or more of involved families, corroborated by coordinator, supervisor, clinicians, and families.
11. Structured Sessions. Multiple- or single-family sessions follow a structured procedure that includes socialization, go-round, response to each family, problem solving, and socialization.	<33% of involved families	33% - 49% of involved families	50% - 64% of involved families	65%-79% of involved families	Documented on standardized checklist for 80% or more of involved families, corroborated by coordinator, supervisor, clinicians, and families.
12. Structured Problem-Solving Techniques. In individual or group sessions, the clinician(s) use a standardized approach (identify the problem, define the problem for one patient/ family, generate >7 solutions, review pros and cons, select a solution, develop specific and individualized tasks and plans) to help families with problem-solving.	<33% of involved families	33% - 49% of involved families	50% - 64% of involved families	65%-79% of involved families	Documented on standardized checklist for 80% or more of involved families, corroborated by coordinator, supervisor, clinicians, and families.